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Arnold Schwarzenegger, Governor  
State of California  
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February 26, 2008

**SENT VIA U.S. MAIL**

Nancy Monk  
Vice Pres., Govt./ Regulatory Affairs  
PacifiCare of California  
5995 Plaza Drive MS CA112-0267  
Cypress, California 90630

**RE: Claims Payment, Provider Dispute Mechanisms, and Administrative Capacity  
Enforcement Matter Numbers 06-185 and 07-356**

**LETTER OF AGREEMENT**

Dear Ms. Monk:

The Department of Managed Health Care's (DMHC) Office of Enforcement recently received a referral from its Division of Financial Oversight (DFO) related to a recent financial survey conducted at PacifiCare of California (PacifiCare). (This referral is designated as Enforcement Matter Number 07-356.) On June 4, 2007, the DFO commenced a non-routine examination and found various violations of both the Knox-Keene Health Care Service Plan Act of 1975, as amended, (KKA), and the undertakings agreed to by PacifiCare, signed after its acquisition by UnitedHealth Group Incorporated ("UnitedHealth Group"). Those violations, and the findings of the exam, are noted below.

The purpose of the non-routine financial examination was to verify corrective actions made by PacifiCare in response to a previous examination memorialized in a Final Report dated December 29, 2005. The recent examination also reviewed PacifiCare's claims processing operations due to the self-disclosure of deficiencies during a site visit on February 7, 2007, as well as to confirm corrective actions taken as a result of this site visit. Also, the DMHC had received, as far back as the year 2006, numerous complaints from providers regarding PacifiCare's claims settlement practices and Provider Dispute Resolution (PDR) system. (These complaints are consolidated in Enforcement Matter Number 06-185, and handled jointly herein.)

It should be noted that at all times referenced herein PacifiCare worked collaboratively with the DMHC to resolve all issues that were identified. Moreover, PacifiCare advised the DMHC on numerous occasions that it was committed to correcting the deficiencies that were found, as well as maintaining adequate staffing for administrative capacity to effectively perform PacifiCare's duties on behalf of all of its enrollees and its health care providers. In this regard, below is a summary of the noted violations as well as the examination's findings:

### **CLAIMS SETTLEMENT PRACTICES - UNJUST PAYMENT PATTERN**

As part of its review procedures, the DFO reviewed a total of 100 denied claims, randomly selected from the claims system that PacifiCare uses to process its point-of-service (POS) claims called "RIMS." Of that sample, 39, or 39%, were denied incorrectly. The DFO also reviewed claims from PacifiCare's claims system called "NICE." After PacifiCare initially provided the DFO with an incomplete sample of claims to review, PacifiCare provided a new data extract of 50 NICE claims. Of those 50 claims, 15, or 30%, were denied incorrectly as the IPA/Medical Group responsibility, when they were actually PacifiCare's responsibility. Also of note, the DFO's analysis of PacifiCare's POS claims denied from January 1, 2006, through June 14, 2007, noted a total of 40,784 denied claims, of which 22,707, or 55.7%, were denied as duplicate claim submissions, resulting in reprocessing errors and a remediation effort after several providers received letters stating that they had submitted duplicate claims, when they had not.

Section 1300.71, subdivision (a)(8)(F) of Title 28 of the California Code of Regulations (CCR), pursuant to Health and Safety Code section 1371, specifies that a demonstrable and unjust payment pattern/unfair payment pattern may be found when a plan fails to provide providers with an accurate and clearly-written explanation of the specific reasons for denying, adjusting, or contesting a claim at least 95% of the time for affected claims. Based on the above information, PacifiCare was in violation of this regulation.

In addition, the DFO's review included 25 late paid claims from the NICE system. In four of those claims, or 16%, PacifiCare did not pay interest correctly on the late payment, as required by Health and Safety Code section 1371 and 1371.35. Moreover, the DFO reviewed 25 late paid claims from the RIMS system, and out of these, 17 had substantial delays because claims information failed to be manually re-keyed into RIMS after initially processed in NICE.

Section 1300.71, subdivision (a)(8)(K) of Title 28 of the CCR, pursuant to Health and Safety Code section 1371, provides that a demonstrable and unjust payment pattern/unfair payment pattern may be found when a plan fails to reimburse at least 95% of complete claims with the correct payment, including the automatic payment of all interest and penalties due and owing. Based on the above information, PacifiCare was in violation of this regulation as well.

PacifiCare agrees with the DMHC that compliance with prompt payment statutes and regulations are important, and has added 24 employees to work on its POS claims processing and data entry,

centralizing this function in its Cypress, California location. In addition, PacifiCare has added six (6) additional staff to research the root cause of the inappropriate denials based on incorrect determination of financial responsibility that were found in NICE. For these claims, PacifiCare believes that the out-of-area determination programming was inaccurate and that such denials should not recur for this reason. PacifiCare has also agreed to re-train claims processing staff on accurate interest rates for late payments, as well as the appropriate application of the statutory penalty.

### **PROVIDER DISPUTE RESOLUTION MECHANISM**

Another part of the DFO's review included PacifiCare's PDR mechanisms. The DFO found that PacifiCare failed to process provider disputes accurately pursuant to section 1300.71.38 of Title 28 of the CCR. This regulation requires PacifiCare, and its capitated providers that pay claims, to establish a fast, fair, and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes while complying with various other provisions of the KKA, and their applicable regulations.

The DFO reviewed the PDR claims under the standard set forth by the above-referenced regulation. PacifiCare had 45 working days after receipt of the dispute to issue a written determination, stating all of the pertinent facts, and explaining the reasons for its determination. (See Cal. Code Regs., tit. 28, §1300.71.38, subd. (f).) Of 49 overturned provider disputes that were reviewed, 14, or 29%, were resolved incorrectly. Similarly, 14 of the 49, or 29%, were processed outside of the 45-day regulatory standard. Moreover, 11, or 22% of the 49, had letters sent to the providers requesting information that was not needed to process the claim, or some of those letters requested the wrong information. In addition, six, or 30%, of 20 upheld provider disputes that were reviewed had incorrect or inaccurate determination letters, and it was found that this occurred because there was no process for ensuring that results of the review documented in PacifiCare's "REVA" system were interpreted correctly by those responsible for finalizing the claim and issuing the PDR determination.

Further, when a provider would call PacifiCare regarding a PDR claim, PacifiCare lacked an effective system to respond to the call, often instructing the provider to submit another dispute. Finally, during the DFO's review, it was determined that PacifiCare's PDR tracking system, REVA, included "projects," such as first-time claims submissions. Further, PacifiCare was unable to distinguish between these first-time claims and actual provider disputes, impacting the DFO's statistics and complicating an accurate reporting, as required by the KKA. (See Cal. Code Regs., tit. 28, §1300.71.38, subd. (k).) Based on such information, PacifiCare was in violation of all of the above-referenced regulations.

The DMHC believes that adequate provider dispute mechanisms are part and parcel of ensuring a viable and robust marketplace, and the DMHC is committed to ensuring the continued role of the professional as the determiner of the patient's health needs, fostering the traditional relationship of

trust and confidence between patients and their doctors. (Health & Saf. Code §1342, subd. (a).) Moreover, the DMHC is dedicated to promoting among all health care service plans a transparent and fully functioning PDR system, which should further ensure that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management. (Health & Saf. Code §1367, subd. (g).)

In response to this enforcement action, PacifiCare confirms that it too shares the DMHC's commitment to a transparent and fully compliant PDR system. In this regard, PacifiCare hired 18 additional employees to perform functions related to PDR and provider claims issue resolution. In addition, PacifiCare acknowledged that its PDR tracking system, REVA, required certain enhancements to function more efficiently and effectively, and PacifiCare has committed to making those technological enhancements to ensure smoother PDR.

### **ADMINISTRATIVE CAPACITY**

After PacifiCare was acquired by UnitedHealth Group, both PacifiCare and UnitedHealth Group agreed in an undertaking to maintain PacifiCare's organizational and administrative capacity. This undertaking was critical, in that representations were made to the DMHC that resources would be consolidated to create greater efficiency. Those consolidated resources were to include sufficient number of staff employed, including those with decision-making authority to provide immediate resolution to potential problem areas. However, throughout the DFO's recent exam, it was evident that PacifiCare failed to demonstrate adequate staffing for effective administrative capacity. DFO found that PacifiCare failed to properly oversee both claims processing functions and PDRs, as required by Health and Safety Code section 1367, subdivision (g), and section 1300.67.3, subdivision (a)(2) of Title 28 of the CCR. This determination was also based on significant numbers of incorrectly denied claims, incorrectly processed and incorrectly determined provider disputes, and routine underpayment of interest/penalties on late paid claims.

In addition, PacifiCare delegated certain claims payment functions to affiliated and non-affiliated entities, which were responsible for processing more than 50% of PacifiCare's claims. Entities such as Lason Systems, Inc. in Utah; PacifiCare International Limited, in Ireland; PSO, in Texas; PacifiCare Health Plan Administrators, and MedPlans Partners, Inc., all carried certain claims payment responsibilities without sufficient oversight by PacifiCare to effectively conduct the plan's business. For instance, the DFO found that PacifiCare did not provide sufficient oversight over Lason because out-of-network claims in the POS product required manual input by Lason into RIMS after a transition from NICE. PacifiCare failed to effectively oversee this process, resulting in late payment on numerous claims.

Also evidencing a lack of administrative capacity issues, PacifiCare failed to demonstrate to the DFO that it had sufficient staffing and resources to manage its total claims inventory. Further, PacifiCare did not readily provide to the DFO accurate contracts or contract information in order for the DFO to review accuracy of payments. The ready accessibility of contracts is required

pursuant to Health and Safety Code sections 1346, subdivision (a), 1381, and 1382, subdivision (a). Despite this, 13 out of 25 contracts or fee schedules were not provided to surveyors in a timely manner and four of these contracts could not be provided for the RIMS Paid Sample of claims selected for review. PacifiCare maintains that at the time the DMHC's requests for contract information were made, the office responsible for maintaining the contracts was in the process of moving, and those files had already been packed for the move.

With respect to PacifiCare's PDR mechanisms, PacifiCare failed to demonstrate to surveyors that it maintained adequate controls over documents needed to process claims and provider disputes. Documents and other correspondence, such as medical records and letters of agreements with providers, were found held-up in queues on a computer system called Document DNA; none were processed timely. These delays negatively impacted PacifiCare's ability to pay its claims correctly, as well as meet claims processing turnaround times.

All of the above evidenced extensive administrative capacity issues implicating the undertaking referenced above, as well as the KKA and its promulgated regulations. The DMHC believes that administrative capacity is fundamental to ensuring that health care service plans run efficiently and effectively to promote the delivery and the quality of health and medical care to the people of the State of California who enroll in these plans. (Health & Saf. Code §1342.)

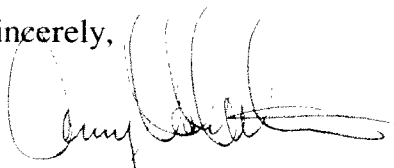
Faced with these deficiencies, PacifiCare advised the DMHC that its ultimate parent, UnitedHealth Group, is committed to providing PacifiCare with all of the resources it needs (staffing, information technology, and funding) to correct all of the deficiencies found by the DMHC. Moreover, PacifiCare concurs that additional oversight of delegated claims processing functions to affiliated and non-affiliated entities is appropriate to ensure compliance with the KKA. Consequently, PacifiCare created a Vice President of Transactions Oversight position to monitor compliance of these delegated functions, as well as all of the other functions retained in PacifiCare's Cypress, California location. In addition, PacifiCare hired 48 additional staff to perform POS claims processing, PDR, and functions related to member and provider claims issue resolution. PacifiCare believes the additional staff, as well as centralizing the POS claims processing functions in Cypress will enhance its administrative capacity. And as for PacifiCare's Document DNA systems, PacifiCare maintains that its total document management inventory, as well as its aged inventory, now shows marked improvement and better turnaround times for timely processing of claims and provider disputes.

Thus, in consideration of all of the above, the DMHC has assessed an administrative penalty against PacifiCare in the amount of \$2,000,000.00. This penalty was assessed pursuant to Health and Safety Code section 1386, subdivision (b)(6). In addition, the DMHC is requiring PacifiCare to engage the services of a monitor to oversee its claims, PDR, and administrative capacity issues for a period sufficient to ensure that PacifiCare is complying with its obligations under both the KKA and the undertakings referenced above.

Ms. Nancy Monk  
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In collaborating with the DMHC toward a quick resolution of this matter, as well as promoting timely implementation of all of the corrective actions promised, PacifiCare has agreed to pay this penalty. PacifiCare has also agreed to engage the services of the monitor, as noted above, within 30 days of signing this Letter of Agreement. Such monitor will be reporting all findings to the DMHC on a regular basis, and as further delineated in the Scope of Work to be provided by the DFO. Finally, PacifiCare understands that the DMHC's Office of Enforcement will maintain jurisdiction over this entire matter until such monitor confirms that PacifiCare's corrective actions were in fact implemented, are adequate, and are effective to resolve the issues identified.

Sincerely,



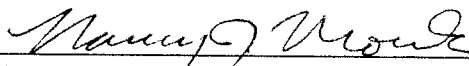
Amy L. Dobberteen  
Assistant Deputy Director  
Office of Enforcement

AAA:mrr

cc: Naomi Yoshihara, Accounting Officer- Department of Managed Health Care

**ACCEPTED BY PACIFICARE OF CALIFORNIA:**

Dated: February 28, 2008



NANCY J. MONK

Vice President, Govt. Relations/ Regulatory Affairs  
PacifiCare of California